jury pattern (after resuscitation from a ventricular fibrillation arrest) has a much higher risk of mortality than a patient with an average inferior myocardial infarction of the type reported in the Fibrinolytic Therapy Trialists' overview, i.e., at least 17.4% on the basis of a simple risk index calculation derived from the InTIME II substudy.[5] Thus, the benefits in this case clearly outweigh the risks.

Paul W. Armstrong
Professor of Medicine
University of Alberta
Edmonton, Alta.

References

1. White H. Thrombolytic therapy in the elderly [editorial]. *Lancet* 2000;356:2028-30.
2. Thiemann DR, Coresh J, Schulman SP, Gerstenblith G, Oetgen WJ, Powe NR. Lack of benefit of intravenous thrombolysis in patients with myocardial infarction who are older than 75 years. *Circulation* 2000;101:2239-46.
3. Stenestrand U, Wallentin L, the RIKS-HIA Group. Thrombolysis is beneficial in elderly acute myocardial infarction patients. *J Am Coll Cardiol* 2001;37(2):323A.
4. Morrow DA, Antman EM, Giugliano RP, Cairns R, Charlesworth A, Murphy SA, et al. A simple risk index for rapid initial triage of patients with ST-elevation myocardial infarction: an InTIME II substudy. *Lancet* 2001;358:1571-5.
5. Armstrong PW. New advances in the management of acute coronary syndromes: 2. Fibrinolytic therapy for acute ST-segment elevation myocardial infarction. *CMAJ* 2001;165(6):791-7.

Risk factors for cardiovascular disease

Most patients do not show any of the conventional risk factors for cardiovascular disease.[1] In a recent *CMAJ* article, Jean-Pierre Després and colleagues emphasized the need to look beyond traditional risk factors, such as the plasma level of low-density lipoprotein cholesterol, as they might not provide enough predictive power for accurate risk stratification.[2] The authors focused on a cluster of factors characterizing the "metabolic syndrome" and especially on the novel measurement of the ratio of total cholesterol to high-density lipoprotein cholesterol.

In a recent study in which we evaluated the cardiovascular risk profile of elderly male patients, we confirmed the limited significance of traditional risk factors, such as total cholesterol or low-density lipoprotein cholesterol levels, and we observed a striking relationship between cardiovascular disease and the ratio of total cholesterol to high-density lipoprotein cholesterol.[3] However, we also noted that the high levels of lipoprotein(a) and homocysteine in these patients may have contributed to the development of cardiovascular complications in our clinical setting. These 2 factors, along with an elevated ratio of total cholesterol to high-density lipoprotein cholesterol, were highly predictive for cardiovascular disease. Therefore we agree with Després and colleagues on the need to look beyond low-density lipoprotein cholesterol and we further suggest that lipoprotein(a) and homocysteine measurements be included when assessing cardiovascular risk.

Giuseppe Lippi
Giancesare Guidi
Istituto di Chimica e Microscopia Clinica
Dipartimento di Scienze Biomedico-Morfologiche
Università degli Studi di Verona
Verona, Italy

References

1. Futterman LG, Lemberg L. Fifty percent of patients with coronary artery disease do not have any of the conventional risk factors. *Am J Crit Care* 1998;7:240-4.
2. Després JP, Lemieux I, Dagenais GR, Cantin B, Lamarche B. Evaluation and management of atherogenic dyslipidemia: beyond low-density lipoprotein cholesterol. *CMAJ* 2001;165(10):1331-3.
3. Lippi G, Arosio E, Prior M, Guidi G. Biochemical risk factors for cardiovascular disease in an aged male population: emerging vascular pathogens. *Angiology* 2001;52:681-7.

Waiting times for cancer surgery

I enjoyed reading the article by Marko Simunovic and colleagues on waiting times for cancer surgery.[1] I was particularly intrigued by the fact that there were no age-related differences in median waiting times from referral to surgery. This is somewhat surprising, given the growing body of literature suggesting that older adults with cancer receive less aggressive diagnostic workups and treatments than younger adults.[2–7]

The investigators analyzed all tumour types together for patients aged 50 years or less, 51 to 65 years and 66 years or more. Given that they demonstrated differences in waiting times across cancer types, and given that some cancers are more common than others in different age groups, this analysis may mask true age-related differences in waiting times. Did the authors examine age-related waiting times separately for each tumour type?

Shabbir M.H. Alibhai
Staff physician
Department of Medicine
University Health Network
Toronto, Ont.

References

1. Simunovic M, Gagliardi A, McCready D, Coates A, Levine M, DePetrillo D. A snapshot of waiting times for cancer surgery provided by surgeons affiliated with regional cancer centres in Ontario. *CMAJ* 2001;165(4):421-5.
2. Alibhai SMH, Krahn MD, Cohen MM, Fleshner NE, Naglie G. Older patients receive less aggressive treatment for clinically localized prostate cancer [abstract]. *Clin Invest Med* 2000;23(5):332.
3. Position paper by the UKCCCR elderly cancer patients in clinical trials working group. *Br J Cancer* 2000;82:1-3.
4. Guadagnoli E, Weitberg A, Mor V, Silliman RA, Glicksman AS, Cummings FJ. The influence of patient age on the diagnosis and treatment of lung and colorectal cancer. *Arch Intern Med* 1990;150(7):1485-90.
5. Silliman RA, Guadagnoli E, Weitberg AB, Mor V. Age as a predictor of diagnostic and initial treatment intensity in newly diagnosed breast cancer patients. *J Gerontol* 1989;44(2):M46-50.
6. Silliman RA, Dukes KA, Sullivan LM, Kaplan SH. Breast cancer care in older women. *Cancer* 1998;83:706-11.
7. Yancik R, Ries LG. Cancer in the aged. An epidemiologic perspective on treatment issues. *Cancer* 1991;68(11 Suppl):2502-10.

[One of the authors responds:]

Our group, like Shabbir Alibhai, was surprised at the lack of a significant difference in waiting times to cancer surgery among our selected age groups.[1] We did examine the relationship between age and time to surgery for each of the 6 cancer types included in the study; there were still no significant variations. We again caution read-